tus. The first case was an early amputation of the foot for gangrene of the toes, followed later on by gangrene in the amputation wound, then the discovery of the diabetes, 5% of sugar being present in the urine, and finally a cure of the wound.

The second case presented gangrene of the foot, occurring within five weeks after a slight operation on the toe, with discovery of the diabetes, 10% of sugar nine days before death. Death 6 weeks after beginning of the gangrene.

The author, in reporting these cases, says that diabetes renders the tissue prone to gangrenous inflammation after the slightest lesions, and unfortunately the diagnosis of diabetes is only made when the gangrenous process has existed for some time.

Quoting König's article in No. 13 of the *Centralblatt f. Chirurgie* for 1887, he states that in serious cases of gangrene the presence of diabetes should not prevent an operation, even though the diabetes has not been ameliorated by treatment, for occasionally the amputation of the gangrenous limb may save the patient's life.—*Deutsche Med. Wochenschrift*, No. 44, 1888.

F. C. HUSSON (New York.)

GENITO-URINARY ORGANS.

I. Radical Cure of Hydrocele. By HENRY MORRIS (London). It may be safely said that there is no treatment of hydrocele, however severe, which has not been followed by relapse. Morris has known of cases of antiseptic incision (Volkmann's) followed by recurrence, and has seen excision of vaginal sac performed with success after both iodine injection and free incision have failed. He relates two cases in which a recurrence of the hydrocele occurred after an excision of the vaginal tunic of the testis, which in all probability was not complete. Unless the entire vaginal investment of the organ is removed there can be no absolute guarantee of success ; the slightest portion left behind may serve as the nucleus of a new formation, as in the case of dermoid, sebaceous and other cysts. The difficulties in the way of an absolute assurance of a complete extirpation of the tunica vaginalis testis, must be apparent.

There does not seem to be any choice, according to Morris, between treatment by injection, on the one hand, and incision and excision on the other, either as to certainty of result or duration of treatment. It does not appear that either the thickness opacity of the sac, the great size of the tumor, the encysted nature of the hydrocele, or even failure of the iodine treatment constitute sufficiently good reason for a rejection of the latter in favor of incision and excision. But on the other hand, there seems to be nothing which need to deter the surgeon from incising or excising a hydrocele under either of the above conditions, unless it be that a cutting operation is objected to by the patient, or deemed dangerous in the individual case. A preference, however, may be given to incision or excision. (1) When we are in doubt as to the precise nature of the relations of the hydrocele sac, *e. g.*, as to whether it is a congenital hydrocele or a hydrocele of a hernial sac. (2) in some cases where hernia, whether reducible or irreducible complicates a hydrocele. (3) Where a foreign body in the tunica vaginalis is the cause of a hydrocele. (4) When, as in a case recently operated upon by Morris, a vaginal hydrocele is associated on the same side with an encysted hydrocele of the cord and a bubonocele. In this case excision of both the hydrocele and the hernial sac and closure of the pillars of the external abdominal ring were successfully accomplished at the same time.—*Am. Jour. Med. Science*, August, 1888.

G. R. FOWLER (Brooklyn).

II. On Inflammatory Diseases of the Seminal Vesicle. By JORDAN LLOYD (Birmingham). This paper is written with the view of showing:

1. That inflammatory disorders of the seminal vesicles and their ducts are not uncommon.

2. That they are in many respects analogous to inflammatory disease of the Fallopian tubes in women.

3. That while occurring sometimes primarily, they are, as a rule, secondary to inflammation of the urethra.